FORM 110-O KENTUCKY DEPARTMENT OF WORKERS CLAIMS
HEARING LOSS/ OCCUPATIONAL DISEASE Frankfort, KY 40601
Revised April 15, 1998

AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT

Workers= Compensation Claim No. _____

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.
Every section should be filled in. If a section is not applicable, fill in the blank with N/A.

_____ Claimant

_____ Social Security Number Date of Birth

_____ Address

_____ City, State, Zip Code

_____ Employer

_____ Address

_____ City, State, Zip Code

_____ Insurer/Self-Insured/Self-Insurance Group

_____ Insurer=s Address

_____ City, State Zip Code

_____ Other participating parties

_____ Address

_____ City, State, Zip Code

HEARING LOSS OR OCCUPATIONAL DISEASE : INJURIOUS EXPOSURE

Occupational disease: _____ Cause of disease: _____
Date of last exposure: _____ County in which exposure occurred: _____Brief description of history of exposure: _____
_____
_____
Body part(s) affected: _____ Length of exposure: _____

MEDICAL INFORMATION

Medical expenses paid: $_____ Date of last medical payment: _____
Medical expenses unpaid or contested: $_____
Surgery performed: _____ Yes _____ No Nature of surgery: _____
Hospitalization(s): _____Yes _____ No Length of hospital stay(s): _____

Impairment ratings: (Attach entire medical report that provides ratings)

	Date Given	Physician
_____%	_____	_____
_____%	_____	_____
_____%	_____	_____

Restrictions on activities -- Attach most recent medical report setting forth physical restrictions.
Diagnosis or diagnoses: _____
_____
If medical treatment is continuing, attach a copy of executed Form 113 indicating designated physician.

WORK INFORMATION

Type of work at last exposure: _____
Average weekly wage at time of last exposure: $_____ Date of return to work: _____
Wages upon return to work:$_____ Type of work performed after return:_____
Type of work performed at time of settlement: _____

BENEFIT AND SETTLEMENT INFORMATION

Amount and duration of temporary total disability paid to date: $_____ X _____ = _____
Per week No. of weeks Total

Monetary terms of settlement: $_____, to be paid as follows: ___ lump sum , ___ weekly for _____ weeks, ____ by annuity, ___ other _____
Total settlement amount: $_____ Percent of permanent disability:_____%
Settlement computation: _____
Does settlement amount include waiver or buyout of ___ past or ___ future medical expenses?
__ Yes __ No. If yes, settlement amount for waiver or buyout: $_____
If settlement terms provide for lump sum representing weekly benefits greater than $10, does claimant have an adequate source of income during disability? _____ Yes _____ No
Source of income:_____ Amount: $_____
Does settlement include retraining incentive benefits? ___ Yes ___ No
If yes, is claimant actively participating in instruction or training program? ___ Yes ___ No
Name of instruction or training program (Attach additional pages if necessary):_____

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):

_____

_____

Other responsible parties against whom further proceedings are reserved: _____

This the _____ day of _____, 19___.

_____ _____
Attorney or representative for claimant (Signature) Claimant (Signature)

_____ _____
Attorney or representative for claimant (Name typed) Attorney or representative for employer

_____ _____
Address Address

_____ _____
City, State, Zip City, State, Zip

_____
Attorney for Special Fund

ORDER APPROVING SETTLEMENT AGREEMENT

IT IS ORDERED that the above Agreement as to Compensation be and the same in hereby **APPROVED.**

This the _____ day of _____, 19____.

_____
Arbitrator/Administrative Law Judge